H-1100 QUALIFIED MEDICARE BENEFICIARY (QMB)

H-1110 GENERAL INFORMATION

Effective January 1, 1988, The Medicare Catastrophic Coverage Act of 1988 required expansion of Medicaid coverage for a mandatory eligibility group of low-income Medicare beneficiaries called Qualified Medicare Beneficiaries or QMB.

The applicant/enrollee must meet all QMB requirements.

A QMB must:

- be enrolled in Medicare Hospital Insurance (Part A); QMBs are not required to be enrolled in Medicare Medical Insurance (Part B),

  Note:
  Supplemental Security Income (SSI) enrollees not already enrolled in Part A are automatically entitled to be enrolled. Certify for QMB and their enrollment will become effective at the time the State begins to pay their premium through Buy-In. Prior to the Buy-In starting, a workflow may be received indicating “Medicare coverage reduced or removed by EDB”. Do not close the QMB certification for these SSI enrollees. Delete this workflow. If you continue to receive this workflow, contact the Buy-In Coordinator who will review the case.

- have income that is less than or equal to 100 percent of the FPIG

  Note:
  In January of each year, disregard the SSA cost of living adjustment (COLA) until the allowed limits are increased **. Thereafter, determine eligibility using all income including the COLA for that year.

- have resources that do not exceed program limits (See Z-900 Resource Limits by Program), and

- meet all non-financial eligibility requirements for Medicaid.

QMB eligibles are divided into two categories:

QMB Only: A person eligible for the limited QMB services only, and

QMB Plus: A person eligible for Medicaid and QMB services

The eligibility determination is the same for both QMB Only and QMB Plus.

H-1110.1 COVERAGE

QMB Only

- Medicare Part A and B premiums,
- Medicare deductibles for Medicare covered services, and
- Medicare co-insurance for Medicare covered services.

QMB Plus

- The same benefits as the QMB Only, plus
- The full range of Medicaid services as entitled by Medicaid in any other category of assistance.

  Note:
  Although the BHSF Form 1-MB Application for Medicare Savings Program is commonly used to apply for initial or continued QMB Plus benefits, it is also acceptable to use BHSF Form 1-A Application for Health Coverage.

SSI enrollees do not have to apply for QMB. When Part A eligibility is received through the BENDEX or EDB interface, MEDS will add a QMB Plus certification. If an SSI enrollee who is entitled to enroll in Part A is not on the system as a QMB, enter a QMB certification.

After closure of a QMB Plus case the enrollee may continue to be eligible as a QMB Only.

An SSI/QMB Plus enrollee remains QMB eligible after he enters a Long Term Care (LTC) facility.

H-1121 ELIGIBILITY DETERMINATION PROCESS

Determine eligibility by applying the following criteria. The elements have been listed in the most logical order, but work on all steps simultaneously.

H-1121.1 DETERMINE ASSISTANCE UNIT

The assistance unit includes the applicant/enrollee.

Note:
Both members of a couple may be applying, but each is certified separately.

H-1121.2 ESTABLISH CATEGORICAL REQUIREMENT

Verify enrollment in Medicare Part A for the applicant/enrollee. Medicare Part A eligibility, the start date for Medicare Part A, and the Medicare claim number may be verified on SOLQ, WTPY, EDB, or BENDEX systems.

H-1121.3 ESTABLISH NON-FINANCIAL ELIGIBILITY

Verify eligibility for each member of the assistance unit with regard to the following factors:

- Assignment of Third Party Rights I-200
- Citizenship/Alien Status I-300
- Enumeration I-600
- Residence I-1900

H-1121.4 ESTABLISH NEED

A. Determine Composition of the Income/Resource Unit

The income/resource unit includes the:

- applicant/enrollee**,**
- applicant/enrollee and ineligible spouse living in the

home, or

- applicants/enrollees who are a couple.

Note:
If the SSA considers the applicants/enrollees as a couple for SSI, they are considered as an eligible couple for the purposes of budgeting in the Medicare Savings Programs (QI, QMB, SLMB) A categorically eligible spouse is one who is aged, blind, or disabled and does not have to be entitled to Medicare for the couple to be considered an eligible couple.

B. Determine Need/Countable Resources

Determine total countable resources of the members of the income/resource unit. Refer to I-1680, Need-Resources, Programs Not Related to LIFC or SSI.

Accept the household's statement of resources unless other objective evidence establishes that the situation is questionable. Verification of countable resources is not required and should not be routinely requested.

Compare countable resources to QMB resource limits:

- for an individual, if there is no spouse, or
- for a couple, if there is a spouse (eligible or ineligible).

Refer to Z-900 Resource Limits by Program.

If countable resources are greater than the limit, the applicant/enrollee is resource ineligible.

If countable resources are equal to or less than the limit, the applicant**/**enrollee is resource eligible. Continue with determination of need/countable income.

C. Determine Need/Countable Income

Individual

If the applicant/enrollee is an individual with no spouse or with an ineligible spouse with no income, compare to QMB standard for one person.

Complete the following budget steps:

Step 1. Determine total unearned income.

Step 2. Subtract $20 SSI disregard from unearned income.

Step 3. Determine total gross earned income.

Step 4. Subtract any remainder of $20 SSI disregard from gross earnings.

Step 5. Subtract earned income deduction from remaining gross earnings. Earned income deduction is $65 and one half of remainder of earnings.

Step 6. Combine remainders from Step 2 and Step 5.

Step 7. Compare to Income Standard for Individual.

If income is equal to or greater than the individual limit, the applicant/enrollee is ineligible.

Ineligible Spouse Deeming

If there is an ineligible spouse with income, complete budget Steps 1 through 7 above using only the applicant/enrollee income. If the income is equal to or greater than the individual limit, the applicant/enrollee is ineligible and there is no deeming. Consider for Medically Needy Program (MNP).

If the applicant's/enrollee's income is less than the QMB standard for one, apply deeming policy (See I-1420 Need - Deeming). Go to Step 1 of the couple budget.

Couple

If both members of a couple are potentially eligible, or if there is income remaining in the deeming process, complete the following steps:

Step 1. Determine the countable unearned income. For a couple, combine all unearned income.

Note:
When deeming income from an ineligible spouse, the

income of the ineligible spouse remaining after allocation for ineligible children is combined with the income of the eligible spouse. The couple is then treated the same as an eligible couple for budgeting purposes.

Step 2. Subtract one $20 SSI disregard per income unit, if applicable.

Step 3. Determine total gross earned income by combining the couple's gross earned income.

Step 4. Subtract any remainder of $20 SSI disregard from gross earnings.

Step *5*. Subtract one earned income deduction from the remaining gross earnings of the income unit. The earned income deduction is $65 and one half of the remainder of the earnings.

Step 6. Combine the remainders in Step 2 and Step 5.

Step *7*. Compare total countable income to the QMB standard for number in the income/resource unit.

If the income is equal to or greater than the QMB standard for a couple, the applicant/enrollee is not eligible.

If the income is less than the QMB standard for a couple, the applicant/enrollee is income eligible. Refer to Z-200 Federal Poverty Income Guidelines.

Exception:
If a couple, both QMB applicants/enrollees are in a nursing facility or receiving Waiver services, consider income using the method that is most advantageous.

If one spouse is in a nursing facility or receiving Waiver services and his spouse is at home and not receiving Waiver services, consider income of each individual for separate QMB decisions.

H-1121.5 ELIGIBILITY DECISION

Evaluate all eligibility requirements and verifications received to make the eligibility decision.

H-1121.6 CERTIFICATION PERIOD

The certification period shall not exceed twelve (12) months. Certify effective the month after the month eligibility is established. Eligibility shall not be retroactive.

H-1121.7 NOTICE OF DECISION

Send the appropriate Notice of Decision to the applicant/ enrollee.

Note:
Applicants enrolled in Medicare Part A but are not eligible for Medicaid are not referred to the Federally Facilitated Marketplace (FFM).